**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

JOHN A SAZY MD
431 OMEGA DRIVE SUITE 104
ARLINGTON TX 76014

**Respondent Name**
HARTFORD CASUALTY INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 47

**MFDR Tracking Number**
M4-13-1851-01

**MFDR Date Received**
MARCH 19, 2013

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Pt. was a new referral with Lumbar Injury, as such Dr. Sazy had to bet a lot of information…this was a high complexity visit & all criteria & requirements were adequately met. This should be paid"

**Amount in Dispute:** $285.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "From our Coder with her credentials in E/M codes: The provider billed a 99205-this would be a new patient, high level office visit. This is Texas, a no down code state. The providers appeal letter is very compelling, however, per CPT, part of the History Component that the provider mentions as thoroughly and fully reviewed, is severely lacking the documentation to support the Review of Systems (ROS)…A high complexity Medical Decision Making (MDM…not satisfied, Moderate complexity satisfied. The decision is to continue to uphold the 99205 denial."

**Response Submitted by:** Gallagher Bassett

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 30, 2012 | CPT Code 99205 | $285.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputes service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 15- (150) Payer deems the information submitted does not support this level of service.

- 15-(150) This line was included in the reconsideration of this previously reviewed bill.

**Issues**

1. Does the documentation support level of service billed?

**Findings**

1. 28 Texas Administrative Code §134.203(a)(5), states "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."
   CPT code 99205 is defined as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family."
   The respondent states in the position summary that "

   A review of the office visit report finds that "part of the History Component that the provider mentions as thoroughly and fully reviewed, is severely lacking the documentation to support the Review of Systems (ROS)…A high complexity Medical Decision Making (MDM…not satisfied."

   Review of the submitted documentation finds that the requestor did not meet the requirements in the ROS to support billing CPT code 99205 per the CMS evaluation and management guidelines. As a result, reimbursement is not recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 10/17/2013<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**